PATIENT NAME _____ **DATE** _____

DOB _____ **PHONE NUMBER** _____

DIAGNOSIS_____

I CERTIFY THAT THE ITEMS LISTED BELOW ARE MEDICALLY NECESSARY FOR THE TREATMENT OF THE PATIENT FOR THE ABOVE CONDITION

☐ Vista® MultiPost

☐ Vista® TX

☐ Vista® Collar

☐ Vista® CTO4

☐ Vista® CTO

DISPENSE AS WRITTEN **DO NOT SUBSTITUTE**

_____ _____ M.D.

UPIN# **PHYSICIAN SIGNATURE**

MK505A 5/14

ADVANCED MEDICAL BROKERAGE

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